BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **MITCHELL S. WAGNER, M.D.** Holder of License No. **27272** For the Practice of Medicine In the State of Arizona.	Board Case No. MD-01-0258 **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand)

On September 4, 2002 Mitchell S. Wagner, M.D., ("Respondent") appeared before a Review Committee ("Review Committee") of the Arizona Medical Board ("Board") with legal counsel, Paul Giancola for a formal interview pursuant to the authority vested in the Review Committee by A.R.S. § 32-1451(P). The matter was referred to the Board for consideration at its public meeting on December 4, 2002. After due consideration of the facts and law applicable to this matter, the Board voted to issue the following findings of fact, conclusions of law and order.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 27272 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-01-0258 after receiving the statutorily required notification from St. Joseph's Medical Center ("Medical Center") regarding possible unprofessional conduct regarding Respondent's care and treatment of a 20 year-old male patient ("A.G.") who was brought to Medical Center's emergency room on January 1, 2001 after being involved in a motor vehicle accident.

4. The records indicate that Respondent examined A.G. on January 1, 2001 and his impression was a stable pelvic ring fracture and an unstable left acetabulum

fracture, probably requiring open reduction and internal fixation. Further radiographic studies confirmed the presence of the left acetabulum fracture.

5. A.G. was brought to the operating room on January 5, 2001 for Respondent to perform surgery to repair the acetabulum fracture. A.G. was intubated and under general anesthesia. The nurses' notes reflect that all of the documents in the chart referred to a left acetabulum fracture and A.G. was positioned on the operating table for a left-sided procedure. The notes reflect that after reviewing the radiographs that were available in the operating room, which indicated that the fracture was on the right side, Respondent repositioned A.G. for a right-sided procedure. After beginning the procedure on the right side, Respondent was unable to palpate a fracture line along the pelvis so he obtained an intraoperative x-ray with a fluoroscope and realized there was no fracture on the right side. Respondent closed the wound and prepped the left side and repaired the acetabulum fracture on A.G.'s left side.

6. In his reply to the Board Respondent stated that all available radiographs within the operating room were mislabeled and showed the acetabulum fracture as being on the right side. Respondent also stated that there were no physical signs of injury to either of A.G.'s lower extremities to clarify which side the fracture was on. Respondent stated that he assumed his initial interpretation of the fracture being on A.G.'s left side was wrong. Respondent stated that he dictated a post-operative report that explained why A.G. had one large incision that crossed the midline along the anterior abdominal region, but did not indicate that he had begun the procedure on A.G.'s right side.

7. The Chief of the Orthopedics Department at Medical Center indicated that Medical Center uses two protocols for designating the appropriate side to be operated on – one is the Academy of Orthopedics recommendation that the surgeon initial the injured

side with a skin marker. The second is the Medical Center's protocol that requires the patient mark the injured side with a skin marker.

8. At the formal interview Respondent testified that A.G. was brought to the operating room from the trauma intensive care unit intubated and unable to communicate with Respondent. A.G.'s inability to communicate made it impossible for Respondent to use either protocol mentioned by the Chief of Orthopedics for identifying the surgical site. Respondent stated that with elective procedures, when he is able to communicate with the patient in advance of surgery, he uses both methods to identify the surgical site.

9. Respondent stated that he always orders three separate x-rays for pelvic fractures and he ordered the three for A.G. These x-rays were in the operating room and were mislabeled as indicating the fracture was on the right side. Respondent stated that when he reviewed the x-rays in the operating room before performing the surgery he wrongly determined that A.G.'s documentation was incorrect and that the x-rays were correct. Respondent stated that since pelvic x-rays are symmetrical it is difficult to tell if they are mislabeled.

10. Respondent stated that now when he deals with a pelvic fracture where the patient is unable to communicate and there no signs of external injury, or if the patient is not in traction and the appropriate side has not been identified, he obtains an intraoperative fluoroscopic x-ray to confirm the proper side.

11. Respondent stated that in retrospect he wishes he had woken A.G. up and had a chance to review the situation before he proceeded. Respondent was asked whether he consulted with anyone when he realized the x-rays indicated a different side than the initial notes. Respondent stated that he consulted with the nursing staff and that they went over the chart and everything in the chart said left side, but the x-rays they had showed the right side. Respondent stated that he was concerned that he had made a

mistake in his January 1 examination notes since he was unable to speak to A.G. when he made the note. Respondent noted that he was working from the x-rays.

12. Respondent explained his surgical approach as from the front along the inguinal region. Respondent stated that he starts low and then works his way up and that not long into A.G.'s operation he realized there was not a fracture line where it should have been and that is what prompted him to get the intraoperative x-ray. Respondent stated he stopped the procedure, washed out the wound, closed it and then prepped the left side, which had not been completely prepped. Respondent stated he then continued the surgery from the incision. Respondent stated that although he initially began the procedure on the incorrect, A.G. did not have a longer scar than normal because the normal operative course for an acetabulum fracture involves the area from the midline all the way out to where the iliac wing is.

13. Respondent was asked how he concluded that the fracture was on the left side when he initially examined A.G. on January 1. Respondent testified that his examination of A.G. was not very informative because A.G. was sedated and paralyzed and Respondent could not find a way to determine which side was broken in the physical examination. Respondent stated that when he and the nursing staff viewed the x-rays in the operating room, he assumed he had initially made a mistake when he viewed the x-rays on January 1. Respondent stated that he was aware before he started the procedure that there was some confusion over the x-rays because of the difference in the x-rays as he had seen them on January 1 and as he saw them in the operating room.

14. Respondent agreed that he did not meet the standard of care because when he initially realized there was a difference in which side was indicated as having the fracture he did not determine with absolute certainty which side he was supposed to repair.

15. Respondent stated that his biggest error, other than beginning the procedure on the wrong side, was what he did in dictating his report. Respondent stated that he was extremely emotionally distraught over the whole event and made a bad decision about how to document what had taken place in the operating room. Respondent noted that if he had taken some time to speak with colleagues and let his emotions work their way out and not be so panic-stricken that he would have made a better decision regarding how to proceed with his dictation. Respondent also stated that he performed A.G.'s procedure approximately one month into private practice, that he was nervous about what had happened and he did not know what to do. Respondent stated that he felt very alone and he made a big mistake in not talking to his colleagues.

16. The standard of care required Respondent to confirm which side the fracture was on before beginning the procedure and to perform the surgery on the correct side of A.G.

17. Respondent's conduct was unreasonable under the circumstances, given the standard of care, because he did not confirm with absolute certainty which side he was supposed to operate on and because he did not operate on the correct side. A.G. suffered harm because the surgery was begun on the wrong side.

18. Respondent made false statements in his dictation that he performed an open reduction internal fixation of the left acetabulum fracture via ilioinguinal approach extending to the right hemipelvis for reduction of the fracture and did not state that he began the procedure on A.G.'s right side.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances above in paragraphs 5, 6, 9, 14 and 16 through 18 constitute unprofessional conduct pursuant to A.R.S. § § 32-1401(24)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the pubic;") and 32-1401(24)(t) ("[k]nowingly making any false or fraudulent statement, written or oral, in connection with the practice of medicine. . . .")

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, IT IS HEREBY ORDERED that Respondent is issued a Letter of Reprimand for operating on the incorrect side and knowingly making a false medical record.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. Pursuant to A.R.S. § 41-1092.09, as amended, the petition for rehearing or review must be filed with the Board's Executive Director within thirty days after service of this Order and pursuant to A.A.C. R4-16-102, it must set forth legally sufficient reasons for granting a rehearing or review. Service of this order is effective five days after date of mailing. If a motion for rehearing or review is not filed, the Board's Order becomes effective thirty-five days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 5th day of December, 2002.

ARIZONA MEDICAL BOARD

By _____
BARRY A. CASSIDY, Ph.D, PA-C
Executive Director

ORIGINAL of the foregoing filed this 5th day of December, 2002 with:

Arizona Medical Board
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Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Certified Mail this 5th day of December, 2002, to:

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Executed copy of the foregoing mailed by U.S. Mail this 5th day of December, 2002, to:

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Copy of the foregoing hand-delivered this 5th day of December, 2002, to:

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